A STATE POLICY AGENDA TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

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ABSTRACT: This report provides state policymakers with a menu of policy interventions that have been implemented to address disparities in minority health and health care. The authors divide these state and local programs into those targeting infrastructure, management, and capacity, and those targeting specific health conditions. Based on their review, the authors identified eight key needs that state and national policymakers will need to consider: consistent racial/ethnic data collection; effective evaluation of disparities-reduction programs; minimum standards for culturally and linguistically competent health services; greater minority representation within the health care workforce; expanded health screening and access to services (e.g., through expanded insurance coverage); establishment or enhancement of state offices of minority health; involvement of all health system stakeholders in minority health improvement efforts; and creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

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EXECUTIVE SUMMARY

The 2002 report of the Institute of Medicine, *Unequal Treatment,* documents deep and pervasive disparities in health and health care for racial and ethnic minority populations in the United States. The National Disparities Initiative, launched in 1998 to eliminate these racial and ethnic disparities by 2010, was important for acknowledging health disparities and for lending the problem a greater and more appropriate moral urgency.

A national strategy to achieve a public health goal most often requires the involvement of the states. Many states now sponsor specific health programs that help members of racial and ethnic minorities, but health disparities as such have not been a high-level issue. Elevating the importance of the discussion is essential, however, for the creation of new interventions. Policy advances in states frequently lead to policy innovation at the federal level as well.

This report was developed to give state policymakers a menu of policy interventions that would address minority health disparities. The authors divide proposed interventions into two broad categories: State Infrastructure and Capacity and Health Conditions. The first covers management and capacity issues necessary to address the broad range of disparities; the second addresses disease and other health-specific issues needing state intervention.

The section Health Conditions includes all six components of the National Disparities Initiative, along with other categories where there are disparities. In State Infrastructure and Capacity, categories were selected through consultation with a National Advisory Panel of state officials and other experts familiar with the disparities issue. This agenda is not proposed as exhaustive or all-inclusive and is intended to provide state policymakers with an array of potential policy initiatives that may be pursued individually or as components of broader, omnibus legislative efforts. Not all interventions and proposals described herein are appropriate for every state, though all are worthy of consideration.

Each category in the agenda includes a description of research defining the problem, examples of promising practices currently in operation in states and localities, and policy recommendations for state policymakers. Below is a summary of key policy recommendations for each category of the agenda.

State Infrastructure and Capacity

Cultural and linguistic competency. States can develop standards tailored to community needs, collect data to identify service needs, finance interpreter services, and increase the supply of minority health providers. Los Angeles County, California, and the Department of Social and Health Services of Washington State have been active in the setting of standards for cultural and linguistic competency. Legislated requirements for translation and interpreter services are embodied in California's Dymally-Alatore Bilingual Services Act and Kopp Act.

Data. States have a critical role in fostering collection, analysis, and use of minority health data for the identification and amelioration of disparities. Some state surveillance systems' racial and ethnic classifications, however, are very narrow. Some states still categorize all racial and ethnic groups as black or white only. The accepted national standard for data collection is the race and ethnicity categories in the Office of Management and Budget's Directive 15.

Elderly. States can help minority elderly by promoting broader availability of home- and community-based services and by assisting income eligible seniors to qualify for full Medicaid or Medicaid-financed coverage of Medicare cost sharing. New Jersey's Senior Gold Program is an example of the prescription drug assistance programs created by some states to aid seniors who are ineligible for Medicaid. As the states revise these programs in light of the 2003 Medicare prescription drug act, the unmet needs of minority elderly should be addressed.

Insurance coverage. More than half of U.S. uninsured belong to racial and ethnic minorities. For them, Medicaid and State Children's Health Insurance Programs make available important and otherwise unobtainable coverage. States should expand eligibility, encourage take-up, and eliminate administrative obstacles to promote wider coverage.

Primary care. States can expand the number and capacity of community health centers, reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations. California's Physician and Surgeon Incentive Licensing Program helps physicians establish practices in underserved localities. The California legislature requires the regents of the University of California to maintain data and report about recruitment of medical students from underserved areas, and the university system's Community-Based Health Professions Education Partnership Program encourages the development of undergraduate medical and other health professional clerkships in primary care combining health education, human services, and

community involvement. Research and development on local health networks is the subject of work by the federal Department of Health and Human Services' Agency for Healthcare Research and Quality and the Bureau of Primary Health Care.

Purchasing. States can use their extensive purchasing power to require data collection and reporting, mandate consumer satisfaction surveys, and require specific health interventions. California includes nondiscrimination clauses in its Medicaid managed care contracts. New Jersey's contracts include requirements that health plans create provider networks that can accommodate the language needs of enrollees. Colorado requires that its contractors offer culturally competent health care services.

Regulatory approaches. States can influence professionals, institutions, and health plans by using licensure and other regulatory requirements to address provider and facility shortages in minority communities. Providers applying for certificates of need in New Jersey have to demonstrate that they are improving health care access for persons from poorly served communities.

State infrastructure. States can help minority health offices reduce disparities by ensuring that these offices have adequate financial resources (many are channeling revenue from the Tobacco Settlement), limit staff turnover, foster good relations with other state agencies, legislative and/or regulatory grounding, access to data, and clear performance measures. Legislatures in Arkansas, California, Connecticut, and Florida have given strong backing to minority health commissions and offices. Ohio has a stand-alone Commission on Minority Health, and the legislatures of Indiana and Oklahoma have assigned these responsibilities to their state health departments.

Workforce development. States can foster a more diverse health workforce by diversifying applicant pools, developing incentive programs, ensuring adequate data collection, and using Graduate Medical Education funds more creatively. The Health Resources and Services Administration operates several programs to encourage workforce diversity; the Association of American Indian Physicians has a mentoring program; the Minority Medical Education Program is an effort led by the Association of American Medical Colleges; and New York developed a Minority Participation in Medical Education grant program.

Health Conditions

Asthma. States can address disparities in asthma rates by improving research, surveillance, monitoring, and evaluation. States can encourage standardization of care, support

environmental interventions, and encourage collaborative approaches among providers, payers, school systems, families, public health authorities, and others. California has been active with several programs: an Office of Binational Border Health, which focuses on the Mexico–California border region; the California Asthma Public Health Initiative; and the California Asthma Among the School Aged project. Illinois, New Jersey, and New York also have asthma public health programs for at-risk populations.

Cancer. States can implement screening and prevention programs targeted toward minority communities and can integrate attention to minorities in their comprehensive cancer control plans. Successful programs include a Breast and Cervical Cancer Early Detection program in Mississippi, and the Real Men Checkin' It Out prostate cancer initiative of South Carolina's Office of Minority Health.

Cardiovascular disease. States can enhance the ability of providers to control hypertension in persons who are at risk, encourage provider/community prevention partnerships, and target resources to populations disproportionately affected by cardiovascular disease. The University of Arkansas for Medical Sciences, Maine's Bureau of Health, and Illinois's Department of Public Health Stroke Task Force are among many examples cited in the main body of this paper.

Diabetes. States need comprehensive approaches to reduce risk factors for diabetes, promote early diagnosis, and improve quality of care and self-management practices. States can require insurers to provide coverage for diabetes treatment (46 states had such laws as of October 2002); other programs currently active are the CDC-funded New York Diabetes Control Program and North Carolina's Project DIRECT.

HIV/AIDS. States need multifaceted efforts to prevent the spread of HIV/AIDS, including education and outreach for minority communities; states may consider needle and syringe exchange programs, which reduce transmission without increasing illicit drug abuse. During 2003 Florida's state legislature directed the Department of Health to develop HIV/AIDS programs to help minority communities, including pregnant women and prison inmates; California statute mandates an HIV/AIDS initiative and New Jersey's health and senior services department supports community-based HIV prevention projects.

Immunization. States can research gaps in rates and services, as well as improve minority surveillance; states can use childhood immunization programs as a model for adult programs and consider specific funding sources such as premium taxes. Federal/state

partnerships include the Racial and Ethnic Adult Disparities in Immunization Initiative, launched in 2002 by Health and Human Services, and Vaccines for Children, sponsored through the Centers for Disease Control immunization program. South Carolina created public service announcements, which it ran on minority-oriented radio stations, to encourage vaccination against influenza and pneumonia. Other state outreach and adult and child immunization efforts are described.

Infant mortality. States can increase access to prenatal care for at-risk parents, establish home visitation programs for at-risk communities, conduct appropriate SIDS education in minority communities, and initiate healthy baby education campaigns. The American Academy of Pediatrics' program, Back to Sleep, has helped reduce SIDS rates nationwide. The National Institute of Health worked with community partners to extend the reach of Back to Sleep to African Americans. California has added multiple languages to its SIDS awareness programs to reach Chinese, Vietnamese, Spanish, Arab, Thai, Croatian, and Laotian communities.

Injury prevention. States can develop injury surveillance systems that gather race and ethnicity data. Successful interventions include mentoring programs to reduce violence, alcohol reduction efforts, smoke detectors, drowning prevention, and pedestrian safety. New York's Harlem Hospital Injury Prevention Program is an example of a successful injury-prevention intervention. A smoke alarm giveaway in Oklahoma City contributed to a reduction in fire injuries there, and in Elmira, N.Y., pre- and postnatal home visits by nurses to at-risk mothers helped produce a range of local health improvements.

Mental health. States need to improve the accessibility and delivery of mental health services to minorities, especially through culturally and linguistically competent community-based providers, as well as prevention initiatives. Interpreter mandates, such as those created by the Illinois Mental Health Hispanic Interpreter Act, are valuable. So are such partnerships as the Youth and Family Centers in Dallas schools, which help to integrate physical and mental health care. Model legislation for states has been written into the National Alliance for the Mentally Ill Omnibus Mental Illness Recovery Act.

Obesity, physical activity, and tobacco use. States can set up prevention and education programs to reach minorities, should create environments conducive to physical exercise, and can adopt CDC tobacco guidelines. Numerous state programs, such as Rhode Island's Obesity Prevention and Control program and North Carolina's Healthy Weight initiative work to encourage healthy weight and good nutrition among their clientele. A Cross-Cultural Workgroup on Tobacco in Washington state identifies populations most affected

by smoking. Other laws in many states prohibit tobacco products or tobacco advertising at or even near schools.

Oral health. States can encourage fluoridation of local water supplies, increase outreach to parents, sponsor school-based education programs, improve access with mobile and school-based clinics, and enhance community/migrant health center infrastructure. Programs to widen the use of dental sealants, such as ones that bring dental services to elementary schools, have proven their value in Ohio and Connecticut. Other states (Pennsylvania, Washington, Delaware) have worked to extend dental insurance or increase reimbursement rates under Medicaid to help people see dentists or encourage dentists to widen their practices to the underprivileged.

Key Themes and Findings from the State Disparities Agenda

The 20 categories included in the State Disparities Agenda cover a wide swath of state policies and programs. Eight key needs arise for state policymakers, and those who seek to craft omnibus or multifaceted legislation to address disparities would do well to ensure that any proposal addresses these eight needs:

Better and more consistent data collection. Assessing and reducing disparities depend on accurate and timely data. Yet major inadequacies in data collection hamper efforts within individual states and hinder efforts to understand differences among states. At the extreme, some state surveillance systems still categorize all racial and ethnic groups as black or white only. The accepted national standard for data collection relies on the categories included in the Federal Office of Management and Budget's Directive 15 (revised October 30, 1997): American Indian or Alaska Native; Asian; black or African American; Native Hawaiian or other Pacific Islander; white; and ethnic group: Hispanic or Latino. States should also collect and report health data on the racial and ethnic subgroups that reside there, and they should initiate strategies to identify gaps in available data for small population groups.

Effective evaluation of programs. The initial intention of this project was to identify best practices among state programs, statutes, regulations, and initiatives, but the researchers soon confronted a shortage of research assessing and documenting effectiveness. We abandoned the term "best practices" for the more ambiguous "promising practices." Practices are identified as promising based on case studies and other reports, as well as recommendations made by researchers, policy experts, and state officials. Our inability to find best practices prompts our recommendation that researchers and public officials work together to evaluate the effectiveness of disparities interventions and to document and publicize those programs and policies that yield positive results. Equally

important is the need to identify interventions that do *not* work so that resources can be channeled productively.

Emphasize stronger cultural and linguistic competence in all disparities reduction activities. Culturally and linguistically appropriate services are health services that are respectful of and responsive to cultural and linguistic needs. Cultural sensitivity is the ability to appropriately respond to the attitudes, feelings, or circumstances of individuals or groups sharing a common and distinctive racial, national, religious, linguistic, or cultural heritage. Language and cultural barriers have been found to increase health costs. States need to develop minimum standards for culturally and linguistically competent health services; undertake data collection and research on successful practices; support education, training, and development of a more competent workforce; and monitor and enforce the effectiveness of implemented programs. In all of these priority areas, states need support from the federal government and foundations.

Workforce development programs and improvement to the cultural competence of all health care professionals. Although Latinos, African Americans, and American Indian/Alaska Natives account for 25 percent of the U.S. population, they account for only 6 percent of practicing physicians and less than 14 percent of registered nurses. White physicians and dentists are far less likely than their minority colleagues to practice in federally designated shortage areas, to see minority patients, and to accept Medicaid patients. Racial concordance of patient and provider is associated with greater participation in care, higher patient satisfaction, and greater adherence to treatment. States have undertaken many initiatives to improve the "pipeline" of minority practitioners, but states need to expand and improve efforts to diversify the health care workforce, and they need assistance in identifying best practices.

Health screening and access to services (insurance). Many state, county, and local public health authorities identify illnesses among their disadvantaged residents through health screening services, and then have no resources or ability to provide treatment. The majority of the nation's 43 million uninsured are racial and ethnic minorities. Lack of health insurance coverage has been identified as the single most important factor in explaining differences between the health status of African Americans and Hispanics versus whites.[1] Unfortunately, the recent state fiscal crisis has caused the loss of public insurance coverage for about 1.6 million lower-income Americans.[2] States that want to reduce or eliminate disparities have no choice but to confront inequities in the availability of affordable and decent health insurance.

Focus on creating and/or improving state minority health offices and infrastructure. Thirty-five states and territories have a designated office, commission, council, or advisory panel on minority health. These entities advise state policymakers about disparities and other gaps, and develop strategies, programs, and solutions. Still, there are no commonly accepted standards, core competencies, or minimum infrastructure requirements for state minority health offices. Successful offices have: adequate financial resources; low turnover; close working relationships with other key state agencies; statutory or regulatory grounding; access to good data on disparities and minority health; and operate with clear performance measures. A promising combination in a state is an office of minority health as well as a standing commission that involves major state stakeholders (legislative, executive, and nongovernmental).

Involve all health system stakeholders. Issues related to minority health and health disparities can be easily pigeon-holed so that policymakers have only limited exposure to them. Yet any effective strategy requires the full engagement of state governments—including executive and legislative branch leaders—and the broader health sector—including hospitals, physicians, community health centers, nurses, home health providers, the public health community, community-based organizations, and more. An effective strategy must also engage the broader public through community-based public education activities and programs.

Finally, we include a recommendation directed not to state policymakers but to national policymakers and national health sector leaders, including organizations of health philanthropy:

Create a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities. As important as states are in developing a winning strategy to eliminate disparities, they cannot carry out this mission alone. The federal government already plays a critically important role in supporting state-based activities. It is also important for the nongovernmental sector, working nationally, to encourage and support state-based efforts to eliminate disparities. We propose the establishment of a national coordinating council on state activities. Such a group can serve a number of critical purposes, including:

- Conducting and supporting research on best practices;
- Developing strategies to advise states;
- Publicizing nationally the strategies of states confronting disparities successfully;
- Educating state officials and other state stakeholders on developments in reducing or eliminating disparities.